Strategic Plan
2007 – 2009

HOME CARE QUALITY AUTHORITY
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Section 1: Introduction

The Home Care Quality Authority is a small agency of Washington State government and is governed by a nine-member board consisting primarily of former and/or current consumers of long-term in-home care services and includes representatives from the Developmental Disabilities Planning Council, Governor's Committee on Disability Issues and Employment, State Council on Aging and the Washington State Association of Area Agencies on Aging. An executive director manages the Authority operations, various contractors and staff members.

The Home Care Quality Authority was established by citizen initiative in November 2001 to improve the quality of long-term in-home care services provided by individual providers through improved regulations, higher standards, increased accountability, and the enhanced ability of consumers to obtain services. In carrying out its duties, the Authority recognizes that individual providers include both family and non-family members.

In addition, the Authority was created to encourage stability in the individual provider work force. The unique relationship the Authority has with individual providers necessitates an on-going commitment to effectively work with consumers, legislators, other offices and departments of state government and the individual providers' bargaining representative for the purpose of encouraging the stability in the workforce.

During the 2002 legislative session, the legislature incorporated the text of the initiative into state law (RCW 74.39A.220 to 290). In May 2002, the Governor appointed the nine-member board and in June the board held its first meeting. A permanent director was hired in October 2002.

During the 2004 legislative session, the legislature made several significant changes to the statute under which the Authority was created. One of the principle changes provided that the Governor, rather than the Authority as was set out in the statute previously, is the public employer of individual providers solely for the purposes of collective bargaining. In addition, the Governor or the Governor's designee appointed under chapter 41.80 RCW represents the "public employer" for bargaining purposes and the Authority provides input during bargaining in order to communicate issues relating to the long-term in-home care services received by consumers.

During the 2005 legislative session, the HCQA was provided with funding to develop and test an accessible referral registry database. The agency was also awarded a $1.4 million dollar demonstration grant from the Centers for Medicaid and Medicare Services to implement four (4) Referral and Workforce Resource Centers in nine counties of the state that put into operation the Referral Registry Database.

During the 2006 legislative session, the legislature required the Authority to obtain on-going, informed input from consumers of in-home services (employers of individual providers) regarding all issues that are raised during the collective bargaining process that have an impact on consumer choice. The legislature also

directed the agency to implement referral services throughout the state of Washington.

Mission

To improve the quality of long-term in-home care services provided to the state's aging adults and persons with disabilities who wish to live independently in their own home through better regulations, higher standards, increased accountability and the enhanced ability of consumers to obtain services. The Authority will encourage stability in the individual provider work force through participation in collective bargaining and enhanced training opportunities.

Vision

Support individuals who require long-term, in-home care according to their needs, values, and interests, and will never leave consumers without the ability to access service providers. To accomplish this, the Authority will provide assistance in locating trained professional individual providers through Referral and Workforce Resource Centers.

Core Values

- *Leadership*

The Washington State Home Care Quality Authority leads other states by making quality home care available to consumer/employers by ensuring, through the Board's representation, the consumers' self-determination and interests. The Board will foster stable and professional career opportunities for individual providers.

- *Diversity*

The Authority will always represent the diverse consumer populations we serve by understanding each population's uniqueness. The Authority will give equal attention to families of children with disabilities, aging adults and adults with disabilities who use and need individual caregivers for personal care and respite services.

- *Advocacy*

The Authority will work in collaboration with consumer/ employers and other advocates to mobilize and inform consumer/employers for the purpose of encouraging improvements in the quality and availability of long-term in-home care.

Individual providers will be held accountable, in accordance

• *Accountability*	with the Authority's standards, for the long-term in-home care they provide. The Authority's standards will continually reflect the consumer/employers' interests and needs.
• *Quality*	Quality in-home care, appropriate to the individual consumer/employer's needs, is available to all.
• *Innovation*	The Authority will strive to actualize innovative ways to achieve our vision through dynamic employer/provider relationships in the collaborative development of Washington State's model home care system.
• *Collaboration*	The Authority will continue to work with consumer/employers and consumer groups, agencies, and community services already in place to strengthen, enhance, or change existing services to better reflect the consumers' interests and needs.
• *Integrity*	The Authority will conduct all business openly and above-board with consumer/employers, individual providers, the governor, the legislature, and the public at-large.
• *Empowerment*	The Authority will strive to empower consumer/employers and individual providers to further develop a superior home care system.

Statutory References (Revised Code of Washington):

The enabling legislation for the Home Care Quality Authority is found in RCW 74.39A.220 to 74.39A.290.

Rules (Washington Administrative Rules):

The Home Care Authority has rule-making authority and these rules are found in WAC 257-01 (HCQA Organization); WAC 257-05 (Safety); and WAC 257-10 (Referral Registry).

The Authority also offers administrative hearing opportunities for individual providers who are removed from the Referral Registry and these rights are covered under Chapter 34.05 RCW of the Washington Administrative Code.

Priorities of Government:

The Home Care Quality Authority services contribute to the statewide Priorities of Government results by **improving the security** of Washington's **vulnerable children and adults** through in-home referral registry services provided by locally-

contracted Referral and Workforce Resource Centers. These centers screen potential workers, follow-up on worker placements and provide extra training to both workers and consumers of in-home services. In addition, these services provide access to the needed personal care services which allows people to remain in their own homes and communities and thereby **improves the health of Washingtonians.**

Through the HCQA's workers compensation, risk management, and claims programs, the **safety** of in-home workers **is improved**.

Section 2: Strategic Planning Approach

Expectations are outlined in legislation	The expectations for the Authority are stated in the Revised Code of Washington chapter 74.39A.220 – 74.39A.290
Planning horizon of six (6) years	This strategic plan represents the Home Care Quality Authority's planned direction through 2013. The Authority has prepared this strategic plan to confirm direction, communicate expectations, guide decision-making, establish priorities and provide a road map to its intended goals and objectives.
The plan is dynamic to be used as a guide for reaching our goals	The plan can be equated to the score for a symphony that will include many participants and a collaborative effort to meet its intended results in concert. It is also a dynamic document – changing as needs and circumstances change, updated when needed, but constantly used as a reference tool to stay on course.
The plan was developed with input from stakeholders	In addition to the direction from the initiative and legislation, this strategic plan has been developed with input and participation of the board members, Authority staff, and input from consumer/employers and other interested parties.

Definitions

The strategic plan uses the following terminology:

Goal	Broad, high-level, issue-oriented statements of future direction or desired state; statement of overall expectations; the "what."
Strategies	Methods for achieving goals; the "how."

Objective	Specific initiatives to accomplish within a stated period of time.
Dates	The time period in which the objectives will be performed.
Measures	Indicators that demonstrate results.
CSF	Critical Success Factor(s) – the most important circumstances that must be in place for the objective to be successful.

Section 3: Trends in Customer characteristics

Between February 1, 2005 and February 28, 2006, **2345 individuals** were screened to participate as potential workers on the Referral Registry in the nine county area (Lewis, Thurston, Mason, Spokane, Whitman, Pend Oreille, Ferry, Stevens and Snohomish counties). Of this number, **1795 were qualified to participate** on the registry. There were **550 people** who were screened, but did not qualify or participate in the registry, Prospective applicants were not placed on the registry for a variety of reasons including; failed criminal background checks, employment found elsewhere, lack of participation in the enrollment process or they simply withdrew their names.

Figure 1: The number of prospective individual providers continues to grow

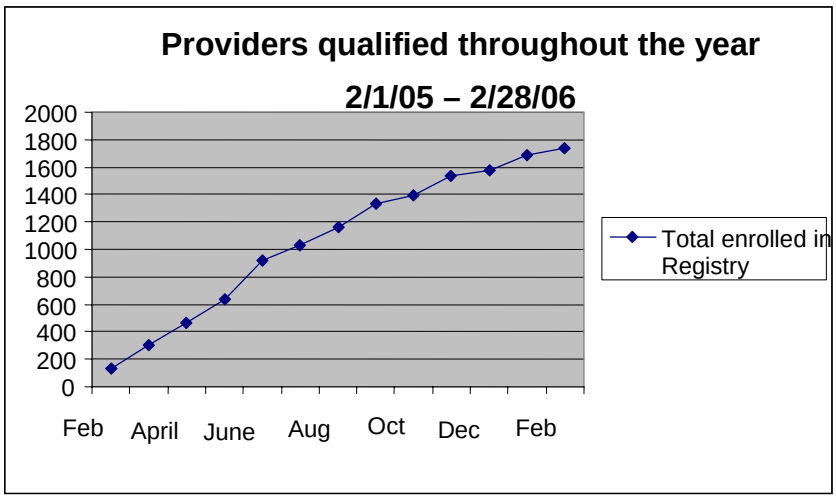

Figure 1

During this same time frame, **676 consumer requested referrals** were provided within this nine county area. Consumer-employers select the criteria for matching based on their needs and preferences and the referral registry through a computerized matching process matches consumer-employers to available workers. For each referral request by a consumer, the registry matched consumer-employers to workers 100% of the time. Each referral list had an average of 7 worker names on the list.

Data on the numbers of prospective workers hired from the registry indicates that about 34% of the time a referral is made to a consumer, a worker is hired from the registry. This is self-reported data and potentially is low due to the nature of self-reports. The RWRCs are working on improving the data reported by employers.

Figure 2: Consumer-employers hired a worker from the Referral Registry 34 % of the time

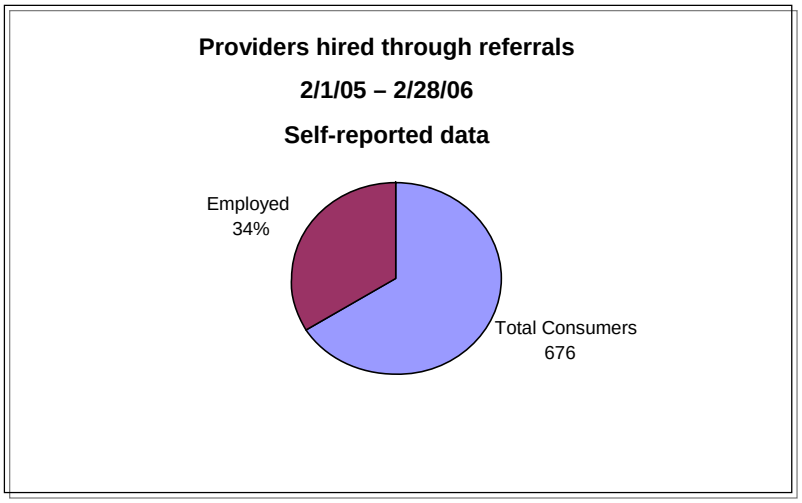

Figure 2

Registry Satisfaction:

Registry Coordinators are required to contact all consumer-employers at one and three-month intervals after the consumer-employer has used the referral services. The computerized findings from consumer-employers indicate that:

- Current satisfaction **with referral registry services** rates high (4.7) on a scale of
  5 = excellent and 1 = unsatisfactory.

- Current consumer-employer satisfaction rates **with the individual providers** found on the registry was also relatively high (4.4) on a scale of 5 = excellent and 1 = unsatisfactory.

Level of Care:

Consumer-employers who use the referral registry services tend to have higher acuity needs than those who do not use the registry services.

- HCS consumer-employer's (who are using the registry) CARE assessment classification indicates that over **62% are authorized at or above the Level C** classification.

- DDD consumers (who are using the registry) CARE assessment classification indicates that over **68% are authorized at or above the Level C classification**.

In a recent HCQA survey, **31% of consumers** who used Medicaid and state-funded in-home services and were **NOT** related to their caregiver indicated that they had **gone without individual provider services** for more than three days. In the same study, **46% of consumers who were related** to their caregiver identified that they had gone without individual provider services **more than three days**. According to DSHS data, at least 60% of the people in community services have high activities of daily living, psychological problems and/or have cognitive impairment. The **high level of care** of individuals who receive in-home services **requires a consistent, qualified and available workforce**.

The **trend for the delivery of long-term care services in an individual's home** will continue to increase as the number of persons with disabilities grows in both the young adult and older populations. In addition there are national trends (**self-determination movement)** and federal U.S. Supreme Court decisions (**Olmstead Decision**) that have promoted the **growth in the number of people** who use Medicaid in-home services.

The use of **individual providers** in the delivery of in-home care services offers consumers a **choice and consistency** in delivery of services and has proven to be **cost-effective**. **Stabilizing** the individual provider **workforce** will assist in improving the **quality of care**.

Individual providers contribute greatly to the Medicaid and in-home care services provided by the state. In recent JLARC study, consumers of in-home services

identified that they **preferred hiring an individual provider** to obtaining the services of a home care agency. The reasons provided by the study participants included being able to select whom they would employ, and being able to develop a consistent relationship with the same worker, rather than having a new, rotating home care worker in the home. Home care agencies however, offer the consumer another choice and are many times more available in emergent staffing situations.

In a recent HCQA survey of **DSHS and AAA case managers**, it was identified that was difficult to find individual provider workers when needed. In this same survey, **71%** of the professional staff indicated that they **would utilize the services of a statewide-centralized database of qualified workers**. Close to one-half of the respondent's reported that their clients could not find an individual provider at least "a few times per year" and that it took a **minimum of one to two weeks or longer to find a worker**.

Section 4: Appraisal of external environment:

The **external environment** that the Home Care Quality Authority operates in is multifaceted. The agency operates with direction from both the legislative and executive branches of state government. The federal Medicaid program (Title XIX) also directs the activities of the agency. Other authorizing environment include, but are not limited to, consumers of in-home services (both private and publicly funded), Area Agencies on Aging, Developmental Disabilities Council, Governor's Committee on Disability and Employment Issues, State Council on Aging, in-home care workers, Service Employees International Union, Washington Protection and Advocacy System, various consumer advocacy groups, Office of Financial Management (Office of Labor Relations), the Department of Social and Health Services (DSHS) and the Department of Labor and Industries (L&I).

The **public expectations** of the agency revolve around initiative I-775, which had significant approval from the citizens of Washington. In general, the initiative promoted higher standards and accountability of in-home care workers. Accessibility to workers was also a dominant theme of the initiative. All of these expectations are currently being implemented through the operations and implementation of Referral and Workforce Resource Centers (RWRCs) throughout the state. These centers provide referral services, regular screening of the individual providers, and additional training for workers and consumer employers.

The public has also expressed the desire to have the referral registry services expanded to serve other individuals. Presently, the RWRCs serve individuals who receive Medicaid services. As of February, 28, 2006, three RWRC centers had received over 250 requests from other individuals looking to employ in-home workers. The other factor that is playing into the need to expand referral services to other consumers is the need for increased return-to-work options for the individual provider workforce after either sustaining a workplace injury, or after the death or loss of their consumer/employer.

Other expectations from stakeholders include the following:

- Elevating the quality of individual provider services through Referral and Workforce centers and HCQA rules that determine who is qualified to be placed on the statewide referral registry and under what circumstances people are removed from the Registry;
- Fair and just treatment of individual providers who are removed from the Referral Registry
- Involving local entities (both private and public) in the implementation of the referral registry;
- Accessibility of referral registry services to consumers with multiple disabilities;
- Consumer involvement in the development of public policy and the collective bargaining process;
- On-going input from employer consumers and people with disabilities through the use of information technology;
- Maintaining a low workers compensation claims rate;
- Accessing and addressing the needs of parent and relative providers and how their needs differ from non-related individual providers;
- Coordinating investigative efforts of individual providers with Adult Protective Services and Children Protective Services;
- Developing an electronic interface of APS and HCQA databases as it relates to APS registry and HCQA Referral Registry;
- Working with DSHS and AAA case managers in locating individual providers for consumer/employers;
- Locally contracted RWRCs effectively communicating with DSHS and AAA staff;
- Establishing the ability for consumer/employers to obtain new individual provider services that are pre-contracted or pre-authorized for emergency or back-up support;
- Providing training opportunities for consumers (including the people who arrange and oversee the direct care of a consumers) and individual providers;
- Providing communication processes for employer consumers and employee individual providers which promote positive employer/employee relationship;
- Working in partnership with DSHS, Area Agencies on Aging (AAA) and other state and local agencies in the development and implementation of quality assurance programs and training programs;
- Encouraging public policy and activities which support self-directed care;

- Obtaining informed input from employer consumers and various consumer advocacy groups during the collective bargaining and sharing this information with the Office of Financial Management, Labor Relations during the collective-bargaining process; regarding issues important to consumers of long term in-home care services;
- Communicating and seeking input from various consumer groups (including people who arrange and oversee the direct care of a consumer) regarding the quality of in-home care;
- Sharing information with various partner agencies and groups; and
- Encouraging the stabilization of the individual provider workforce.

The Home Care Quality Authority plans to **address the above expectations** through the **implementation of the strategic plan**. Activities of the agency that are already in process and that address some of these expectations include the following:

- Continuation of statewide RWRC Advisory Committee to advise on the development and expansion of referral registry services;
- Development of various workgroups to address registry and training implementation issues;
- Development and implementation of consumer driven training curriculum;
- Implementation of Referral and Workforce Resource Centers throughout the state and expansion of customers served;
- Implementation and expansion of worker safety training and 'return to work' programs through the Referral Registry; and
- Utilization of information technology to reach consumer/employers.

The associated challenges that the HCQA faces include the following:

- The need to maintain a balance between available workers and consumers/ employers who are in need of services.
- Communications and outreach to consumer/employers who have disabilities and are unable to leave their homes or communities;
- Obtaining informed input from consumer/employers during the collective bargaining process;
- Return to work program is somewhat limited due to the nature of the employment relationship between the consumer/employer and the individual provider worker;

- Inadequate funding to support HCQA operations and initiatives;
- Consumer expectations may not be met due to funding constraints or other implementation constraints;
- Pressure to increase wages and benefits for all providers that may cause higher costs to all consumers;
- Legislative and/or consumer support may not continue if the HCQA is perceived as not adding value to the long term care system;
- Historical credibility gap and/or mistrust of "bureaucracy" by consumer/employers; and
- Liability related to placement and/or removal from the Referral Registry.

The opportunities to help manage expectations and mitigate risks include the following strategies:

- Preparing a convincing business case for all funding requests;
- Seeking grants and private funding whenever possible;
- Working efficiently, taking advantage of established resources and networks;
- Educating state policy makers and others regarding the need for quality in-home care services, qualified care providers and the growing demand for services;
- Not promising more than can reasonably be delivered;
- Consistently communicating the scope of services;
- Utilizing existing resources when possible;
- Collaborating with consumers and providers to demonstrate credibility, goodwill, commitment and extraordinary effort to meet the goals and objectives;
- Communicating with consumers about the scope of services and authority;
- Involving consumers in solutions;
- Developing an effective information technology plan;
- Seeking legal counsel advice as needed;
- Conducting routine agency risk assessments;
- Evaluating program development activities based on Priorities of Government criteria and GMAP outcomes; and
- Actively participating in the negotiation process and seeking consumer /employer input during the collective bargaining process.

- Consumers' feelings of loss associated with the transfer of negotiation responsibility from HCQA to the Governor's designee.

Section 5: Goals, Strategies and Objectives

Goal 1: Improve the quality and accessibility of home care services.

Strategy 1 ***Use what exists first; connect the dots, then fill the gaps in order to improve the ability of the agency to achieve results efficiently and effectively.***

Objective 1.1	Consumer/employer satisfaction rates for individual provider services will be increased compared to consumer/employer satisfaction rates obtained in 2006.
Dates	July, 2008
Measure	Survey results Compared to 2006 consumer/employer results, the number of consumer/employers satisfied with individual provider services will improve.
CSF	✓ Reliable and valid measures are developed to ensure accurate survey results ✓ Sufficient number of consumer/employer participants are obtained,

Objective 1.2	Increase the presence of the HCQA at the local level via existing advocacy groups and organizations in order to gather information on long-term care services.
Dates	July 2007- ongoing
Measure	Tracking report from HCQA board members and staff. The number of presentations by board members and staff will increase by 10% each year.
CSF	HCQA board member contacts with local groups that have

	interest in long term care in-home services; ✓ Identification of appropriate local groups; ✓ HCQA resources and availability of board and staff.
Objective 1.3 Dates Measure CSF	Increase the use of existing electronic communications channels (website, newsletter, listservs, etc.) that collects and disseminates information. July 2007 – on-going Lists of communications channels used. The numbers of communications will increase each year by 10%. ✓ HCQA resources to utilize existing communications channels. ✓ Cooperation of other electronic communications channels
Objective 1.4 Dates Measure CSF	Ensure that consumers/employers have access to a volunteer resolution process to resolve employer/employee issues through the Referral and Workforce Resource Centers. July 2007 Presence of program with written procedures—Number of consumer participants will increase by 10% annually. Baseline number to be established by July, 2008. ✓ Adequate funding and resources ✓ Adequate training of RWRC staff and consumer/employers

Strategy 2 ***Reach out, communicate and collaborate with current and prospective consumer/employers and providers, partner agencies, community organizations, educators, other health care service providers, and the general public to achieve objectives and improve agency efficiency and effectiveness.***

Objective 2.1	Increase the knowledge of consumer/employers, individual providers, partner agencies and the general public regarding in-home services, RWRC services and consumer/employer rights through the use of HCQA agency website, and

	consumer/employer and worker resource clearinghouse.
Dates	July 2007: Ongoing
Measure	Website and clearinghouse use will continue to increase over time (30% annually). Short periodic website knowledge quizzes will demonstrate knowledge of topic presented.
CSF	✓ HCQA resources ✓ Understanding of audience and most effective communications media. ✓ Understanding of informational needs of audience

<u>Objective 2.2</u>	Increase statewide media presence and subsequently establish connections that educate and inform the media and public about who the HCQA is—the agency's mission, services and goals.—and activities of the Referral and Workforce Resource Centers.
Dates	July 2007-2009
Measure	List of targeted media and evidence of information releases.
CSF	✓ HCQA resources. ✓ Effective communications that conveys the information in an understandable format. ✓ Responsiveness of media
<u>Objective 2.3</u>	Ensure that audiences are informed of HCQA activities and services in quarterly newsletters.
Dates	July 2007 – ongoing
Measures	Quarterly HCQA and Safety Training Newsletters and annual measurement of perceived usefulness of the newsletters.
CSF	✓ Information that captures HCQA mission, vision and goals ✓ Input from constituency groups

Objective 2.4 Dates Measure CSF	Implement information technology systems that are available to board members and sub-committee members that encourage consumer/employer participation. July, 2007 – 2009 Total consumer/employer participation will increase over time by at least 10% annually. ✓ Adequate IT equipment available to consumer/employers
Strategy 3	***Implement a financial strategy that will achieve adequate funding for HCQA objectives and mandated programs.***
Objective 3.1 Dates Measure CSF	To actively seek outside funding sources on a quarterly basis, including both state and federal funding sources that further the goals and mission of the agency. July 2007- June 2009 List of outside funding sources and evidence of pursuing appropriate and needed resources. Appropriate funding sources obtained. ✓ Availability of outside funding sources that are appropriate to HCQA Mission.
Objective 3.2 Dates Measure CSF	Evaluate cost/benefit of RWRC services implemented on an annual basis. June 2008 and June 2009 Average cost per customer served will decrease over time. Baseline as of 2/28/06 is $181.00/customer served. ✓ Appropriate data collected.

Goal 2: Assist in stabilizing and expanding the workforce to meet the needs of current and future consumers.

Strategy 4 ***Obtain informed input from consumer/employers during the collective bargaining process and provide information to the Governor or Governor's designee during the collective bargaining process.***

Objective 4.1 Dates Measures CSF	Increase consumer/employer participation in providing input during the collective bargaining process. Ongoing - 2013 HCQA Employer subcommittee will meet at least monthly during the collective bargaining process. The Committee will have representation from the various advocacy groups and consumer/employers served. ✓ On-going working relations with consumer groups ✓ Utilization of appropriate communication strategies ✓ Effective outreach to in-home consumer/employers
Objective 4.2 Dates Measures CSF	Increase consumer/employer knowledge of the collective bargaining process and advocate for consumer/employer issues. Starting April 1 of each year prior to the expiration of the contract. Evidence of information collected from consumer/employers. ✓ Effective relations with consumer/employers of service. ✓ Effective relations with governor or governor's designee for collective bargaining.
Objective 4.3 Dates Measures	Increase the use of the Referral and Workforce Resource Centers (RWRCs) as a means to promote worker support, accountability, and quality. July 2007– on-going Quarterly reports from RWRCs demonstrate increased IP participation in Referral and Workforce Resource Center (RWRC) activities (15% increase annually).

CSF	Enhanced skill development and participation in RWRC training activities (10% of IPs on referral registry will have completed specialty training by October 1, 2008). ✓ Effective recruitment and retention strategies in place
<u>Objective 4.4</u> Dates Measures CSF	Ensure an efficient and effective worker's compensation and claims risk management program. July 2007 – on-going Monthly, quarterly and annual reports that reflect satisfactory participation of contracted third-party administrator for the IP worker's compensation program. IP worker's compensation claims rates will remain low. (Original goal was no more than 220 per month). ✓ Good working relations with all involved stakeholders ✓ Ability to assess and take appropriate action when needed. ✓ Program management skills ✓ Funding and support necessary to implement contract
<u>Objective 4.5</u> Dates Measures CSF	Ensure an adequate return to work program through the Referral and Workforce Resource Centers and the Referral Registry. July to August 2007 development work –thereafter on-going Indemnity rates will remain low. ✓ Adequate number of consumer/employers to hire workers based on working restrictions; ✓ Effective claims management and investigations of claims
<u>Objective 4.6</u> Dates	Ensure that benchmark and performance indicators in the implementation of collective bargaining agreement are met. After approval and funding (if necessary) of negotiated contract.

Measures CSF	Benchmark and performance indicators are successfully met. ✓ Agreement with appropriate 3rd party administrators or organizations needed to implement negotiated contract. ✓ Adequate data to evaluate benchmark and performance indicators.

Strategy 5 **Establish expanded training curriculum and training opportunities for individual providers that assist in improving the security of vulnerable children and adults.**

<u>Objective 5.1</u> Dates Measure CSF	Increase the individual peer-mentoring program to serve all RWRC areas (currently serving 4 RWRC areas). July – October, 2007 development of program through RWRCs November – December, peer mentors selected and trained January, 2008 to June 30, 2009, implement program Satisfaction survey (95% satisfaction of IPs who use the program are satisfied with peer-mentoring survey). Evidence from consumer/employers that program helped improve the quality of in-home services. Funding available to implement program
<u>Objective 5.2</u> Dates Measures	Improve knowledge through individual provider training, including safety training and specialty training for individual providers. Specialty training to begin October, 2007 Safety training—ongoing Demonstrated knowledge of training through testing or survey of IPs who complete the training. Number of IPs who obtain specialty training (10% of IPs on Referral Registry will obtain specialty training designation) by October 2008. Number of IPs that receive safety training (100% of all IPs will receive safety training within 120 days after employment

CSF	by a consumer/employer). IP satisfaction of safety training (98% of IPs will be satisfied with training provided). ✓ HCQA resources to monitor training. ✓ Resources to conduct and pay for training. ✓ Resources to track training output and performance measures. ✓ Appropriate funding to obtain this goal.
<u>Objective 5.3</u> Dates Measure CSF	Increase supplemental knowledge delivered via non-conventional methods (primarily on-line) to support existing training offered by HCQA, DSHS and others. July 2005----on-going – 2013 Number of Web-published tips, hints or helps will increase over time. ✓ HCQA staff resources ✓ Collaboration with stakeholders

Strategy 6 ***Expand and improve recruiting of individual providers which will contribute to improved accessibility of workers for vulnerable children and adults.***

<u>Objective 6.1</u> Dates Measure CSF	Improve recruiting strategy for general individual provider services. July 2007- ongoing Number of IPs on referral registry (Increase of number of IPs on referral registry over time—15% annually). ✓ HCQA resources to implement strategy. ✓ HCQA resources to evaluate monthly numbers recruited and placed on referral registry. ✓ Effective measurement tools.

Objective 6.2	Ensure that an adequate number of emergency/relief IP pool participants are on the Referral Registry to meet consumer/employer demand
Dates	July 2007, --ongoing
Measure	Number of IPs on emergency/relief IP pool (emergency/relief backup pool in each RWRC delivery system has at least 25 IPs available for work)
CSF	✓ IPs willing and able to participate in back-up pool. ✓ Incentives attractive to recruit and retain IPs.

Goal 3: Adequately support a home care provider referral system that is accessible, appropriate and efficient for consumer/ employers and providers and provides choice for consumer/employers

Strategy 7 ***Maintain and monitor Referral and Workforce Resource Centers statewide.***

Objective 7.1	Ensure that on-going policy issues related to the Referral and Workforce Resource Centers, referral services complaints and appeal/fair hearing processes are identified and addressed.
Dates	July 2007--Ongoing – 2013
Measure	Monthly, quarterly and annual monitoring reports demonstrate that 100% of RWRC contracted sites are performing satisfactorily.
CSF	✓ Issues and decisions are adequately tracked. ✓ Ensure *appropriate* stakeholders are involved to identify all issues, resolve them appropriately and ensure resolution does not conflict with other rules or agency policies. ✓ Efficient participation of stakeholders to ensure progress can be made.

Objective 7.2 Dates Measure CSF	Ensure consistent operation of referral registry statewide. July 2007 – ongoing -- 2013 Evidence of quarterly visits or monitoring telephone calls to each contractor for performance reviews. ✓ Ability to accurately assess and evaluate monthly, quarterly and annual reports ✓ Accurate estimate of participating providers and consumers using registry.
Objective 7.3 Dates Measure CSF	Ensure easy access to RWRC services via internet service and a toll-free number. July 2007 – 2013 Results of consumer/employer survey (98% consumer/employer satisfaction with accessibility as evidenced by survey). ✓ Survey adequately developed to measure accessibility issues

Strategy 8 ***Enhance quality of registry workforce***

Objective 8.1 Dates Measure CSF	To advocate for benefits and wages of individual providers that increase the quality of registry workforce and address consumer/employer issues. During the collective bargaining process with the Governor's designee, Office of Labor Relations, Office of Financial Management. Written Negotiated contract with measures that enhance the quality of the registry workforce (i.e. increased training, increased services to consumers, etc) ✓ Good working relations with consumers of services, Governor's Office of Labor Relations, and other stakeholders; ✓ Good representation and presentation of consumer

	quality care issues.

Strategy 9 ***Promote, maintain and potentially expand the registry***

<u>Objective 9.1</u> Dates Measures CSF	Ensure that the referral registry marketing/promotion strategy is consistently applied throughout the state. July 2007 and ongoing 2013 RWRC reports demonstrate that statewide marketing plan is being appropriately utilized. The number of IPs on the referral registry will meet the needs of consumers seeking in-home workers. ✓ Resources to monitor and update effective marketing strategy ✓ Knowledge of audience for marketing strategy ✓ Appropriate evaluation of marketing strategy
<u>Objective 9.2</u> Dates Measure CSF	Expand the referral registry services to include other individuals in-need of in-home services. July 2007—updated referral registry system to accommodate needed changes. October 2007 - January 2008: Implement referral services in the 14 RWRC service delivery areas. Baseline data collected January 2009 and project increase in participation by 15 % annually. ✓ Adequate linkages within the Long Term Care System
<u>Objective 9.3</u> Dates Measure	Expand the registry database as planned (and able) with additional features and/or functionality July 2007 – June 2009, ongoing Additional functionality as planned and needed. System developed to serve other consumer/employers by October, 2007. ✓ Agreement from primary stakeholders on additional

CSF	functionality ✓ Resources to add and maintain additional functionality
Objective 9.4	Assess other potential users of Referral Registry services in the long-term care system.
Dates	September – November, 2008
Measure	Document evidence of evaluation or feasibility study
CSF	✓ Ability to assess need. ✓ Participation of stakeholders in long-term care systems.

Goal 4: Establish training curriculum for consumer/employers (including persons arranging and overseeing the direct care of consumers) related to employing and managing individual providers.

Strategy 10 ***Collaborate with consumer/employers (including persons arranging and overseeing the direct care of consumers) and providers to identify training needs for consumer management of individual providers.***

Objective 10.1	Increase consumer-driven Training Workgroup's participation and planning to develop recommended training strategy.
Dates	July 2007 and on-going
Measure	Documentation of recommendations for training curriculum and delivery.
CSF	✓ Collaboration with stakeholders and partner agencies to ensure complimentary nature of course offerings. ✓ HCQA resources to design curriculum, advertise course offerings, facilitate registration and recordkeeping
Objective 10.2	Coordinate development of complementary consumer curriculum designed to empower consumers through mentoring or by additional training opportunities.

Dates	July – September 2007: Consumer trainers and/or mentors are selected in RWRCs October 2007: Training provided for Consumer mentors November 2007: Consumer/employer mentorship program begins
Measure	98% of consumer/employers are satisfied with consumer/ employer training.
CSF	✓ Collaboration with consumers, family members, providers and partners. ✓ Consideration of resource constraints to develop "practical" curriculum that can be implemented. ✓ HCQA resources to monitor training. ✓ Resources to conduct and pay for training. ✓ Resources for tracking training output and performance measures.

Goal 5: Provide accountability through performance measures, quality improvement, effective internal control and by establishing qualifications and reasonable standards of accountability for the IP registry workforce.

Strategy 11 ***Protect public resources***

<u>Objective 11.1</u>	Ensure that HCQA performance measures are evaluated at least quarterly and appropriate action taken based on evaluation.
Dates	July 2007 – June 2009 and ongoing
Measures	HCQA performance measures are met. Action to change activities to ensure compliance or change measures are identified.
CSF	✓ Effective evaluation of internal control measures by use of risk assessment

	✓ Timely and accurate completion of required reports to the Governor, OFM and other agencies. ✓ Effective monitoring of contracted agents and RWRC sites.
Objective 11.2 Dates Measures CSF	Elevate requirements for placement on registry September 2008 Documented review of requirements and recommendations to Board (after annual consumer/employee survey July 2008). ✓ Established standards for providers ✓ Implemented assessment of provider's ability to provide in-home care
Objective 11.3 Dates Measures CSF	Respond appropriately and timely to complaints July 2007- June 2009 All complaints will be responded to within one (1) business day. ✓ Adequate staff to respond to complaint ✓ Staff understand the nature of complaint
Objective 11.4 Dates Measures CSF	Evaluate consumer/employer satisfaction related to in-home care services and registry: accessibility, ease of use, appropriateness, efficiency, and relevance and consumer choice. July 2008 98% consumer/employer who use RWRC services are satisfied Written evaluation of consumer satisfaction ✓ Adequate resources to conduct evaluation ✓ Availability of consumers to respond to survey

	✓ Evaluation tool accessible to consumers
Objective 11.5 Dates Measure CSF	Ensure that an effective performance indicator data collection strategy is implemented. On-going Management reports with performance measure data. ✓ Resources to implement. ✓ Data are available.

Strategy 12 ***Coordinate with partner agencies to share information.***

Objective 12.1 Dates Measure CSF	Ensure that the collection and sharing of information with partner agencies is complete. July 2007 – on-going Evidence of written collection of information from partner agencies including DSHS, AAA, L&I, OFM, advocacy groups, SEIU and others. ✓ Good communication with partner agencies. ✓ Cooperation and collaboration of partner agencies.

Strategy 13 ***Implement reasonable standards of accountability for individual providers.***

Objective 13.1 Dates Measure CSF	Increase IP accountability standards through the RWRC screening process, communications and training. July, 2007 and on-going Standards are posted in relevant consumer and provider information, and included in training. Providers and consumers know standards, as evidenced by survey feedback. ✓ IP accountability standards are concise and easy to

	understand.
Strategy 14	***Remove individual providers from the Referral Registry for acts of misfeasance or malfeasance.***
<u>Objective 14.1</u> Dates Measurement CSF	Improve quality standards for the individual provider workforce and ensure due process for all involved. July 2007-on-going Documented evidence of investigations for malfeasance and misfeasance and evidence that appeal rights were provided. ✓ Appropriate staff are trained ✓ Adequate funding to support appeal process

Section 6: Performance Measures and Assessment

Performance Measure	Status	Assessment
Implementation of Referral Registry to begin by July, 2005	Due to CMS grant, the Referral Registry was implemented January, 2005	Referral Registry delivery ahead of schedule. State-wide implementation to be complete by August 2006. Need to expand services to include non-publicly funded customers. Need to evaluate other potential customers such as other LTC customers.
Annual baseline number of individual providers recruited and screened will	As of 2/28/06, baseline number of individual providers recruited was 2345	Number of IPs participating in the referral registry is

be established by July, 2006	for the 4 grant sites which serve 9 counties. As of 2/28/06, baseline number of individual providers on the Referral Registry was 1795 for the 4 grant sites which serve 9 counties.	good thus far. 22% of the total number of IPs are participating on the Referral Registry in WA. In comparison to 4 counties in California, 9% of in-home workers participated on their registries.
Statewide, at least 75 percent of consumer-driven referral requests will result in a match. Of those, at least 30% will result in employment by July 2006.	100 % matching rate as of 2/28/06. This rate varies as new RWRCs are initiated as there is a 'building phase' to obtain needed workers. 34% employment rate as of 2/28/06. This rate is expected to fluctuate as new RWRCs are initiated as there is a 'building phase' to educate and inform consumers/employers about the referral services.	Recruitment and enrollment of IPs seems to be very good as matching is high. Meeting employment benchmark. However, need to expand referral services so that there are more opportunities to keep people employed as direct care workers and in order to provide an effective "return to work" program.
At least 50% of individual provider workers will receive safety training by July 2005 and will increase by 10% by July 2006 and annually thereafter for the next three years.	100% of all individual providers receive quarterly safety newsletters in an effort to reach all workers with safety training information. As of 4/30/06, 15,033 individual provider workers obtained the required 4 hours of safety training via classroom, self-study or on-	HCQA will continue to offer a variety of training modalities so that all IPs have the 4 hours of required safety training by December 31, 2006. The need to revise and update the on-line safety training course has been

	line as of July, 2005.	identified and will be completed over the next biennium. Safety training classes for consumer/employers that encourage workplace safety would be of benefit to increase safety in the IP workforce.
There will be no more than 220 workers compensation claims per month	As of 4/30/2006, the average monthly workers compensation claim was 25/month. As of April 30, 2006 the total amount of money paid in premiums was $27.7 million. The total costs incurred for this time period was $2.8 million. The average cost per indemnity claim was $18,954. and the average cost for medical was $3,291.	Continue safety training and information efforts. Continue to explore efforts to reduce premium costs. Revise and update on-line safety training. Provide safety training for consumer/employers.
100% of complaints and concerns are responded to within one business day	All complaints filed to date have been responded to within one business day	Continue complaint review process
At least 80% of consumers who use the referral registry are satisfied with services as determined by annual survey.	Annual survey to be conducted June/July 2006 During RWRC follow-up with consumer/employers at 1 and 3 month intervals the following was reported from 260 consumer/employers: • Current satisfaction with **referral registry services ranks high** at 4.7 on a scale of 5 = excellent and 1 =	Continue to gather information throughout roll-out of services and compare information between the 14 centers.

	unsatisfactory; • Current **satisfaction with individual providers** found on the registry ranks high at 4.4 on a scale of 5 = excellent and 1 = unsatisfactory.	
Reduce the percent of consumers who go without a provider and who also use the referral registry for three days or more by ten percent between July 2005 and July 2006	Survey of consumer/employers to be completed by July 2006.	A comparison between areas that have RWRCs and those that do not will be made to determine if there are differences in how long people go without workers. Outcomes will also be evaluated.
Providers who care for someone other than a family member will experience an increased length of employment as determined by annual survey.	Annual survey of individual providers to be completed by WSU by Fall of 2006	WSU will also evaluate the effectiveness of various strategies, including wages and benefits on IP retention.
Baseline information on various cost efficiencies will be gathered during FY 2006: Referral Registry operating cost Cost ratio of consumers and providers using the registry	Between 2/1/05 and 1/31/06 the costs of operating 4 service delivery areas, serving nine counties was $494,322. This includes the cost of after-hours services and referral registry updates and maintenance. The cost ratio thus far is $181.00 per customer served.	Findings from the grant-funded RWRC sites indicate that costs go down over time due to “building phase” of recruitment of workers and employers.

There are very few similar organizations to compare “industry standards.” Oregon is the only state thus far that has a similar Home Care Quality Authority structure. The HCQA has signed a contract with Oregon to assist in the development of their registry system. This contractual arrangement will benefit Washington and assist in furthering the development of the Referral Registry for our state. In addition, the

HCQA has licensed the use of the Referral Registry to Michigan. In return, Michigan has shared the additional functional developments with the HCQA.

As mentioned above, data from four California counties indicates that the HCQA's Referral and Workforce Centers are performing quite well in comparison to data obtained from referral registries operated in those counties.

In March 2004, the HCQA completed an audit by the State Auditor's Office and did not have any findings or recommendations from that state office.

The Washington Joint Legislative Audit Review Committee will be conducting an evaluation of HCQA activities by end of 2006. A report will be sent to the legislature.

The HCQA has a contract with Washington State University to conduct several surveys, including case manager, individual provider and consumer-surveys. They also will be evaluating the effectiveness of various workforce interventions. Their research will be completed by the end of 2006.

The Center for Medicare and Medicaid Services will be conducting an evaluation of the HCQA's Workforce Demonstration grant in 2007.

Section 7: Strategy and capacity assessment:

The HCQA is a relatively new state agency that employs a staff of four. Although small in size, the organization has strong staff members with various professional expertise that contributes positively to the overall operations of the agency. The staff members include:

- Executive Director (responsible for overall operations and management of the agency and implementation of collective bargaining agreement);
- Executive Assistant (responsible for daily administrative functions);
- Referral Registry Program Manager (responsible for project management of the referral registry and contract management of RWRCs); and
- Communication and Training Program Manager (responsible for implementation of communication strategy, and development of training programs and contract management of the third-party administrator for individual provider workers compensation program).

The agency leases office space from General Administration and obtains information technology (IT) support from Right! Systems, Inc. The agency will 'refresh' computer and printing equipment by the end of June 2006. The agency has obtained a service contract with the Department of Information Services to house the referral registry server. The agency also has a personal service contract with Brewer Consulting Services to maintain and update the Referral Registry database.

The Referral and Workforce Resource centers are operated by 14 locally contracted organizations, including area agencies on aging, employment securities department,

home care agency and a private health service agency. Performance review of the RWRCs thus far indicates that they are meeting expected performance benchmarks. It is expected that there will be continual growth in both number of workers and consumer/employers over the next two years.

Claims management for the individual provider worker's compensation program is contracted out to Sedgwick CMS. This program has been performing very well and the claims rate is significantly lower than originally expected. The monthly total claims averages 25 claims per month. Originally, the agency expected to have initial claims at 220 per month. Classroom, on-line and self-study modules are available to individual provider workers. Safety reference manuals are available in eight (8) different languages. Quarterly safety newsletters are mailed out to over 39,000 individual providers.

The agency obtained a Workforce Demonstration grant from the Centers for Medicare and Medicaid Services which allowed the agency to establish and test the first Referral and Workforce Resource Centers in the state. These centers served nine counties including Spokane, Whitman, Stevens, Pend'Oreille, Ferry, Snohomish, Lewis, Thurston, and Mason counties. The success of these demonstration sites has paved the way for statewide implementation of other RWRCs.

In addition, the grant provided the monies to develop individual provider and consumer training curriculums which will be used by other RWRCs throughout the state. These training modalities have included classroom, on-line, DVD, CD and manual study modalities. The grant also funded a peer-mentorship and professional development program (through local community colleges and other training centers) for individual provider workers.

Due to agency cost-savings and legislative approval, the HCQA will be able to initiate referral registry services throughout the state by August, 2006.

The HCQA is working with OFM Risk Management in conducting an evaluation and plan for mitigation of agency risks and liabilities.

The Agency is currently experiencing increasing numbers of situations in which individual providers are either removed or are denied placement on the referral registry. It is anticipated that the staffing requirements to investigate these situations will also increase. In addition, the need for legal representation and administrative hearing numbers will also increase.